U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 20 April 2006

CASE NO.: 2005-BLA-5644

In the Matter of:

THOMAS FUDALA, o/b/o
FRANK FUDALA (Deceased)
Claimant

v.

GATEWAY COAL COMPANY,
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

Cheryl Cowen, Esq.
For the Claimant

Raymond F. Keisling, Esq.
For the Employer

BEFORE: RICHARD A. MORGAN
Administrative Law Judge

DECISION AND ORDER AWARDING BENEFITS

This proceeding arises from a deceased miner's duplicate claim for benefits, under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq.*, as amended ("Act"), filed on June 12, 2003, respectively. The miner died on November 6, 2004. The case is being pursued on his behalf by his son, Thomas Fudala. The Act and implementing regulations, 20 C.F.R. parts 410, 718, and 727 (Regulations), provide compensation and other benefits to:

1. Living coal miners who are totally disabled due to pneumoconiosis and their dependents;
2. Surviving dependents of coal miners whose death was due to pneumoconiosis; and,

3. Surviving dependents of coal miners who were totally disabled due to pneumoconiosis at the time of their death.

The Act and Regulations define pneumoconiosis ("black lung disease" or "coal workers' pneumoconiosis" ("CWP")) as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment.

PROCEDURAL HISTORY

The miner filed a claim for benefits on June 19, 1986. (DX 1). On December 2, 1986, a United States Department of Labor Claims Examiner denied the miner's claim because he did not prove that he had coal workers' pneumoconiosis or that he was totally disabled due to pneumoconiosis. (DX 1). The miner filed the current claim for benefits on June 12, 2003. (DX 3). The claim was approved by the district director because the evidence established the elements of entitlement that Mr. Fudala had coal workers' pneumoconiosis and was totally disabled due to pneumoconiosis. (DX 49). On November 24, 2004, Gateway Coal Co., through counsel, disagreed with the determination and requested a hearing before an administrative law judge. (DX 50).

On December 9, 2005, I held a hearing in Pittsburgh, Pennsylvania, at which the claimant and employer were represented by counsel.[1] No appearance was entered for the Director, Office of Workman Compensation Programs (OWCP). The parties were afforded the full opportunity to present evidence and argument. Claimant's exhibits ("CX") 1-3, Director's exhibits ("DX") 1-57, and Employer's exhibits ("EX") 1-4 were admitted into the record. Closing arguments were submitted by both parties post-hearing.

ISSUES[2]

I. Whether the miner had pneumoconiosis as defined by the Act and the Regulations?

II. Whether the miner's pneumoconiosis arose out of his coal mine employment?

III. Whether the miner's disability was due to pneumoconiosis?

IV. Whether there has been a change in an applicable element of entitlement upon which the order denying the prior claim became final?

FINDINGS OF FACT

I. Background

A. Coal Miner

[1] Under *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1998)(en banc), the location of a miner's last coal mine employment, i.e., here the state in which the hearing was held, is determinative of the circuit court's jurisdiction.
[2] The parties agree that the miner was totally disabled from his coal mine employment. (TR 7).

Mr. Fudala was a coal miner, within the meaning of § 402(d) of the Act and § 725.202 of the Regulations, for 43.5 years, as stipulated to by the parties. (Hearing Transcript (TR) 6).

B. Date of Filing

The deceased miner filed his claim for benefits, under the Act, on June 12, 2003. (DX 3). None of the Act's filing time limitations are applicable; thus, the claim was timely filed.

C. Responsible Operator[3]

Gateway Coal Company is the last employer for whom the claimant worked a cumulative period of at least one year and is the properly designated responsible coal mine operator in this case, under Subpart G, Part 725 of the Regulations. (DX 4).

D. Dependents

The deceased miner had no dependents at the time of his death for purposes of augmentation of benefits under the Act. (TR 10).

E. Personal, Employment and Smoking History[4]

The decedent miner was born on March 7, 1924. (DX 3). The miner passed away on November 6, 2004. (DX 16). Frank Fudala married Irene Sokal on July 17, 1948. (DX 1). His wife passed away on March 13, 2002. (DX 3; DX 14).

Frank Fudala retired from the mines on April 1, 1986. (DX 3). The claimant's last position in the coal mines was that of a mechanic. His job as a mechanic was an above ground position. During his 43 years as a coal miner, Mr. Fudala also held the following positions: coal shoveler, assistant motorman, mechanic, supplyman, euclid driver, and highlift operator. (DX 4). Some of his positions required him to lift 80 to 100 pounds several times a day.

Mr. Fudala had a history of cigarette smoking. The medical evidence is consistent regarding his smoking history. Mr. Fudala quit smoking in 1964. The physician reports agree that he smoked approximately one pack of cigarettes per day for 20 years. I find that the evidence of record supports a 20-pack year smoking history.

II. Medical Evidence

In the miner's first claim for benefits, Dr. Yong Dae Cho examined Mr. Fudala on August 25, 1986 for the Department of Labor. He noted that the miner smoked one pack of

[3] Liability for payment of benefits to eligible miners and their survivors rests with the responsible operator. 20 C.F.R. § 725.493(a)(1) defines responsible operator as the claimant's last coal mine employer with whom he had the most recent cumulative employment of not less than one year.

[4] "The BLBA, judicial precedent, and the program regulations do not permit an award based solely upon smoking-induced disability." 65 Fed. Reg. 79948, No. 245 (Dec. 20, 2000).

cigarettes per day for 18 years. He also noted that Mr. Fudala had exertional shortness of breath. Dr. Cho diagnosed Mr. Fudala with hypoxia and hypertension. (DX 1).

During the Department of Labor examination, Dr. Garson performed an arterial blood gas study. The results showed a PCO2 of 42 and a PO2 of 66.9. Dr. Garson stated "arterial blood gases demonstrate normal alveolar ventilation with mild hypoxia due to ventilation perfusion imbalance and/or shunting." (DX 1).

A pulmonary function study, performed on July 22, 1986, resulted in an FVC of 3.87, an FEV1 of 3.03, and an MVV of 121. The miner was 62 years old and 68 inches at the time of the study. (DX 1).

A July 22, 1986 chest X-ray was interpreted by Dr. McMahon, a B-reader and Board-certified radiologist, as showing no evidence of pneumoconiosis. (DX 1).

The following is a summary of the evidence submitted since the final denial of the prior claim.

A. Chest X-rays[5]

There were nine readings of five X-rays, taken on January 29, 2003, October 20, 2003, January 6, 2004, May 25, 2004 and May 27, 2004. (DX 20, 27, 28, 29, 30, 31; CX 1, 2, 3). Six are positive, by four physicians, Drs. Ahmed, Cappiello, Cohen, and Thomeier, who, with the exception of Dr. Cohen,[6] are Board-certified in radiology and B-readers.[7] Two are negative, by two physicians, Drs. Renn and Thomeier, both of whom are B-readers. Dr. Thomeier is also a Board-certified radiologist. Dr. Renn is Board-certified in internal medicine and pulmonary diseases. Dr. Navani provided a quality-only reading of the October 20, 2003 X-ray. Dr. Navani found the X-ray overexposed and of poor resolution.

Exh. #	Dates: 1. X-ray 2. Read	Reading Physician	Qualifications	Film Quality	ILO Classification	Interpretation Or Impression
CX 2	5/27/2004 6/4/2004	Dr. Thomeier	B, BCR		1/0	
CX 1	5/25/2004 5/27/2004	Dr. Cohen	B, BCI(P)	2	1/0	

[5] In the absence of evidence to the contrary, compliance with the requirements of Appendix A shall be presumed. 20 C.F.R. § 718.102(e) (effective Jan. 19, 2001).

[6] Dr. Cohen is not a Board-certified radiologist. He is a B-reader and Board-certified in internal medicine and pulmonary diseases. He is a Board-certified medical examiner.

[7] *LaBelle Processing Co. v. Swarrow*, 72 F.3d 308 (3rd Cir. 1995) at 310, n. 3. "A "B-reader" is a physician, often a radiologist, who has demonstrated proficiency in reading X-rays for pneumoconiosis by passing annually an examination established by the National Institute of Safety and Health and administered by the U.S. Department of Health and Human Services. *See* 20 C.F.R. § 718.202(a)(1)(ii)(E); 42 C.F.R. § 37.51. Courts generally give greater weight to X-ray readings performed by "B-readers." *See Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16, 108 S.Ct. 427, 433 n.16, 98 L.Ed. 2d 450 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993)."

Exh. #	Dates: 1. X-ray 2. Read	Reading Physician	Qualifications	Film Quality	ILO Classification	Interpretation Or Impression
DX 20	1/6/2004 1/6/2004	Dr. Renn	B, BCI(P)	1		No parenchymal abnormalities consistent with pneumoconiosis.
CX 3	10/20/2003 6/30/2004	Dr. Cappiello	B, BCR	2	1/1	
DX 31	10/20/2003 6/17/2004	Dr. Ahmed	B, BCR	2	1/1	
DX 30	10/20/2003	Dr. Navani	B, BCR	3		Quality-only reading. Overexposed. Poor resolution.
DX 29	10/20/2003 10/21/2003	Dr. Thomeier	B, BCR	2		No abnormalities consistent with pneumoconiosis. Cardiomegaly and large right pleural effusion.
DX 28	1/29/2003 6/17/2004	Dr. Ahmed	B, BCR	1	1/1	
DX 27	1/29/2003 2/4/2003	Dr. Thomeier	B, BCR		1/0	Mild interstitial changes in the left lung base which could be consistent with pneumoconiosis.

* A-A-reader; B-B-reader; BCR – Board Certified Radiologist; BCP – Board-Certified Pulmonologist; BCI – Board-Certified Internal Medicine; BCI(P) – Board-Certified Internal Medicine with Pulmonary Medicine sub-specialty. Readers who are Board-certified radiologists and/or B-readers are classified, as the most qualified. *See Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16, 108 S.Ct. 427, 433 n. 16, 98 L.Ed. 2d 450 (1987) and *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B-readers need not be radiologists.

**The existence of pneumoconiosis may be established by chest X-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. A chest X-ray classified as category "0," including subcategories "0/-, 0/0, 0/1," does not constitute evidence of pneumoconiosis. 20 C.F.R. § 718.102(b). In some instances, it is proper for the judge to infer a negative interpretation where the reading does not mention the presence of pneumoconiosis. *Yeager v. Bethlehem Mines Corp*., 6 B.L.R. 1-307 (1983)(Under Part 727 of the Regulations) and *Billings v. Harlan #4 Coal Co.*, BRB No. 94-3721 (June 19, 1997)(*en banc*)(*Unpublished*). If no categories are chosen, in box 2B(c) of the X-ray form, then the X-ray report is not classified according to the standards adopted by the regulations and cannot, therefore, support a finding of pneumoconiosis.

B. Pulmonary Function Studies[8]

Pulmonary Function Studies ("PFS") are tests performed to measure the degree of impairment of pulmonary function. They range from simple tests of ventilation to very

[8] § 718.103(a)(Effective for tests conducted after Jan. 19, 2001 (See 718.101(b)), provides: "Any report of pulmonary function tests submitted in connection with a claim for benefits shall record the results of flow versus volume (flow-volume loop)." 65 Fed. Reg. 80047 (Dec. 20, 2000).

sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV1) and maximum voluntary ventilation (MVV).

Physician Date Exh. #	Age Height	FEV1	MVV	FVC	Tracings	Comprehension Cooperation	Qualify Conform*	Dr.'s Impression
Dr. Garson 5/27/2004 DX 21	80 66"	1.40		1.98	Yes	Good Well	Yes	There is no obstructive lung defect indicated by the FEV1/FVC ratio.
Dr. Garson 5/27/2004 DX 21 Post-Bron	80 66"	1.38		1.95	Yes	Good Well	Yes	
Dr. Cohen 5/25/2004 DX 24; DX 26	80 66"	1.36	55	2.04	Yes		Yes	Moderately severe reduction in FVC with a severely reduced FEV1 and a mildly reduced FEV1/FVC ratio.
Dr. Renn 1/6/2004 DX 20	79 67"	1.21	43	1.69	Yes	Good Good	Yes	
Dr. Renn 1/6/2004 DX 20 Post-Bron	79 67"	1.30	46	1.75	Yes	Good Good	Yes	
Dr. Celko 10/20/03 DX 25[9]	79 66"	1.03		1.41	Yes	Good Good	Yes	Severe obstructive vent. Good BD response. Severe reduction DLCO. Unreliable lung

[9] Dr. Kucera, Board-certified in internal medicine with a sub-specialty of pulmonary disease and critical care medicine, reviewed this test and determined that the vents are acceptable.

Physician Date Exh. #	Age Height	FEV1	MVV	FVC	Tracings	Comprehension Cooperation	Qualify Conform*	Dr.'s Impression
								volumes/effort dependent.
Dr. Celko 10/20/03 DX 25[10] Post-Bron	79 66"	1.17		1.48	Yes	Good Good	Yes	
Dr. Garson 1/29/2003 DX 18	78 67"	1.43		1.96	Yes		Yes	
Dr. Garson 1/29/2003 DX 18 Post-Bron	78 67"	1.50		2.00	Yes		No	
Dr. Garson 3/8/2002 DX 18	78 66"	1.62		2.14	Yes	Good Good	No	
Dr. Garson 3/8/2002 DX 18 Post-Bron	78 66"	1.75		2.21	Yes	Good Good	No	
Dr. Garson 7/22/1986 DX 18	62 68"	3.03	1.21	3.87	Yes	Good Good	Yes	

***** A study "**conforms**" if it complies with applicable standards (found in 20 C.F.R. § 718.103(b) and (c)). (*See Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 (7th Cir. 1993)). A judge may infer in the absence of evidence to the contrary, that the results reported represent the best of three trials. *Braden v. Director, OWCP*, 6 B.L.R. 1-1083 (1984). A study which is not accompanies by three tracings may be discredited. *Estes v. Director, OWCP*, 7 B.L.R. 1-414 (1984).

Appendix B (Effective Jan. 19, 2001) states "(2) the administration of pulmonary function tests shall conform to the following criteria: (i) Tests shall not be performed during or soon after an acute respiratory illness…"

Appendix B (Effective Jan. 19, 2001), (2)(ii)(G): Effort is deemed "unacceptable" when the subject "[H]as an excessive variability between the three acceptable curves. The variation between the two largest FEV1's of the three acceptable tracings should not exceed 5 percent of the largest FEV1 or 100 ml, whichever is greater. As individuals with obstructive disease or rapid decline in lung function will be less likely to achieve the degree of reproducibility, tests not meeting this criterion may still be submitted for consideration in support of a claim for black lung benefits. Failure to meet this standard should be clearly noted in the test report by the physician conducting or reviewing the test." (Emphasis added).

[10] Dr. Kucera, Board-certified in internal medicine with a sub-specialty of pulmonary disease and critical care medicine, reviewed this test and determined that the vents are acceptable.

The PFS tests were conducted when the Claimant was between the ages of 78-80.[11] Appendix B does not list qualifying values for miners over the age of 71. For a miner of the claimant's height of 66.5 inches, § 718.204(b)(2)(i) requires an FEV1 equal to or less than 1.60 for a male 71 years of age.[12] If such an FEV1 is shown, there must be in addition, an FVC equal to or less than 2.08 or an MVV equal to or less than 64; or a ratio equal to or less than 55% when the results of the FEV1 tests are divided by the results of the FVC test.

As the parties agree that the miner was totally disabled, the pulmonary function studies are reviewed in evaluating the physician's opinions regarding the cause of the miner's disability. Because disability is not an issue, whether or not the results qualify under § 718.204(b)(2)(i) is irrelevant.

C. Arterial Blood Gas Studies[13]

Blood gas studies are performed to detect an impairment in the process of alveolar gas exchange. This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. A lower level of oxygen (O2) compared to carbon dioxide (CO2) in the blood, expressed in percentages, indicates a deficiency in the transfer of gases through the alveoli which will leave the miner disabled.

Date Exh. #	Physician	PCO2	PO2	Qualify	Physician Impression
5/25/2004 DX 24	Dr. Cohen	39.3	66.5	No	ABGs show moderate hypoxemia.
1/6/2004 DX 20	Dr. Renn	41	56	Yes	
10/20/2003[14] DX 23	Dr. Celko	36 (sitting) 41 (lying down)	60 (sitting) 48 (lying down)	Yes Yes	

* Results, if any, after exercise. Exercise studies are not required if medically contraindicated. 20 C.F.R. § 718.105(b).

Appendix C to Part 718 (Effective Jan. 19, 2001) states: "Tests shall not be performed during or soon after an acute respiratory or cardiac illness."

[11] The PFS test from 1986 was included in the Director's exhibits, but was evidence from the miner's first claim for benefits.

[12] The fact-finder must resolve conflicting heights of the miner on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). This is particularly true when the discrepancies may affect whether or not the tests are "qualifying." *Toler v. Eastern Associated Coal Co.*, 42 F.3d 3 (4th Cir. 1995). I find the miner is 66.5" here, his average reported height.

[13] 20 C.F.R. § 718.105 sets the quality standards for blood gas studies.

> 20 C.F.R. § 204(b)(2) permits the use of such studies to establish "total disability." It provides:
> In the absence of contrary probative evidence which meets the standards of either paragraphs (b)(2)(i), (ii), (iii) or (iv) of this section shall establish a miner's total disability:…
> (2)(ii) Arterial blood gas tests show the values listed in Appendix C to this part…

[14] Dr. Kucera, Board-certified in internal medicine with a sub-specialty of pulmonary disease and critical care medicine, reviewed this test and determined that it is technically acceptable. (DX 23).

D. Physicians' Reports[15]

A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative X-ray, finds that the miner suffers or suffered from pneumoconiosis. 20 C.F.R. § 718.202(A)(4). Where total disability cannot be established, under 20 C.F.R. § 718.204(b)(2)(i) through (iii), or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. § 718.204(b).

Dr. Fino, a B-reader and Board-certified in internal medicine with a subspecialty in pulmonary disease, prepared a report, dated October 12, 2004. (EX 1). Dr. Fino noted a 39 year coal mine employment. He also noted that Mr. Fudala had a 20-year smoking history and quit in the mid-1960's. In regards to the miner's smoking history, Dr. Fino stated "I doubt very much that this has anything to do with the patient's symptomology." (EX 1).

Dr. Fino stated that a pulmonary function study performed two years after Mr. Fudala's retirement showed no obstruction and no restriction. The next pulmonary function study was taken 16 years later. Dr. Fino stated that this study showed a significant restriction defect. Dr. Fino further noted that the pulmonary function studies performed between 2002 and 2004 showed a restriction defect. He stated that one study "suggested" an obstruction defect. Dr. Fino concluded "[E]ven assuming that there was obstruction, it was a qualitative obstruction that did not and has not resulted in any impairment. Clearly, the impairment in this case is restriction." (EX 1).

Dr. Fino disagreed with Dr. Celko's finding of a chronic obstructive lung disease reflected on the Department of Labor examination. Dr. Fino stated that there was no evidence of obstruction based on the normal ratio of the FEV1/FVC. (EX 1).

Dr. Fino firmly stated his conclusion regarding the miner's impairment: "It is totally unreasonable from a medical standpoint to state that coal dust played any role in this man's respiratory impairment. His respiratory impairment, in fact, is not actually related to any lung disease but it is directly related to this man's severe cardiomyopathy." (EX 1). Dr. Fino agrees that Mr. Fudala was totally disabled. He, however, attributes his disability to heart disease.

Dr. Fino prepared an additional report, dated August 19, 2005, after reviewing the following items: (1) July 22, 1986 chest X-ray; (2) an August 25, 1986 arterial blood gas study; (3) the death certificate; and (4) Dr. Cohen's June 1, 2005 deposition. Dr. Fino concluded that none of this information changed his finding of impairment and disability due to severe cardiomyopathy. (EX 2).

[15] *Dempsey v. Sewell Coal Co. & Director, OWCP*, ___ B.L.R. ___, BRB Nos. 03-0615 BLA and 03-0615 BLA-A (June 28, 2004). Under (new) 2001 regulations, expert opinions must be based on admissible evidence.

Dr. Reddy, Frank Fudala's treating physician, prepared a report, dated October 1, 2004. Dr. Reddy is Board-certified in internal medicine. (DX 22). He noted that he began treating Mr. Fudala on May 31, 2002. He examined the miner on at least 16 occasions. His last examination of Mr. Fudala was on June 9, 2004. Dr. Reddy notes a 41-year coal mine employment and a 13-year smoking history. He also noted, however, that some of his records indicate a 20-year smoking history. He states that Mr. Fudala quit smoking "many years" prior to his death. (DX 22).

Dr. Reddy stated that Mr. Fudala's tests reveal a "significant and severe pulmonary defect, severe diffusing impairment and hypoxemia." Dr. Reddy prescribed oxygen to help with Mr. Fudala's breathing problems. (DX 22).

Dr. Reddy concluded that Mr. Fudala suffered from pneumoconiosis. Dr. Reddy states "[T]he slow progression of his breathing complaints is consistent with pneumoconiosis caused by coal mine employment." (DX 22). Dr. Reddy noted that Mr. Fudala also suffered from a significant restrictive defect, a reduced diffusing capacity and hypoxemia. Dr. Reddy states that the facts of his condition are consistent with pneumoconiosis. (DX 22).

Dr. Reddy opined that Mr. Fudala suffered from both legal and medical pneumoconiosis. Dr. Reddy stated that he would make a diagnosis of legal pneumoconiosis even if the X-ray evidence was deemed negative for medical pneumoconiosis. (DX 22).

Dr. Reddy concluded that Mr. Fudala was totally disabled. He noted that his last coal mining job required him to lift over one hundred pounds on a regular basis. He noted "Mr. Fudala is disabled from that job in light of his reduced pulmonary function studies, reduced diffusion capacity and pulmonary complaints. Even after the administration of bronchodilators, Mr. Fudala's pulmonary function study results were significantly abnormal." (DX 22).

Dr. Reddy noted that Mr. Fudala's coal dust and silica exposure is far greater than his cigarette smoking exposure. Dr. Reddy defined Mr. Fudala's coal dust exposure as "significant and substantial." Dr. Reddy concluded that Mr. Fudala's coal dust exposure is a significant contributing factor in his pulmonary disability. He also noted that cigarette smoking and cardiac problems played an additional role in the disability. Dr. Reddy stated that Mr. Fudala complained of shortness of breath prior to his significant heart problems. As such, he determined that Mr. Fudala would not have been as disabled if he did not have significant exposure to coal dust. (DX 22).

Dr. Garson, an A-reader and Board-certified in preventive medicine, prepared a report, dated August 12, 2004. Dr. Garson noted that he examined Frank Fudala on June 7, 2001 and again on August 12, 2004. He stated that Mr. Fudala complained of shortness of breath and wheezing on occasion. Dr. Garson noted a 39 year coal mine employment. (DX 21).

Dr. Garson stated that he found X-ray evidence of "pneumoconiosis which showed some mild interstitial nodularity in the left mid and lower lung fields and the classification was s/t with profusion 1/0 indicative of coal workers' pneumoconiosis simple." (DX 21).

Dr. Garson noted that Mr. Fudala also had heart disease and diabetes. Dr. Garson performed a pulmonary function study. He stated that Mr. Fudala showed insignificant response to the use of bronchodilators.

Dr. Garson also concluded that Mr. Fudala was disabled due to his pulmonary problems. He opined that Mr. Fudala's "pneumoconiosis and his other pulmonary abnormalities" were substantial contributing factors to his pulmonary disability. (DX 21). Dr. Garson noted that Mr. Fudala quit smoking many years prior to the examination. As such, he stated that "it is clear" that his pneumoconiosis apart from the effects of smoking played a substantial contributing factor in Mr. Fudala's impairment. (DX 21).

Dr. Cohen is a B-reader and Board-certified in pulmonology and internal medicine. He prepared a consulting medical evaluation, dated June 16, 2004. (CX 1). Dr. Cohen examined Mr. Fudala on May 25, 2004. In addition to his examination of the miner, Dr. Cohen also reviewed the other physician reports and medical records. Dr. Cohen described the miner's symptoms as progressively worsening shortness of breath, dyspnea on exertion and paroxysmal nocturnal dyspnea. Dr. Cohen noted the miner's past medical history as diabetes, hypertension, ischemic cardiomyopathy, congestive heart failure, atrial fibrillation, bilateral carotid artery stenosis and prostate cancer. Dr. Cohen noted a 42-year coal mine employment and a 20-year smoking history. (CX 1).

During his examination of the miner, Dr. Cohen found decreased air entry on the right side of the chest and crackles at the left base. Dr. Cohen interpreted an X-ray as positive for pneumoconiosis with a profusion of 1/0. He also found pleural disease and diffuse pleural thickening on the chest X-ray. Dr. Cohen noted that if the X-ray was interpreted as negative, it would not change his opinion regarding coal workers' pneumoconiosis. (CX 1).

Dr. Cohen diagnosed Mr. Fudala with coal workers' pneumoconiosis. Dr. Cohen opined "his chronic respiratory condition is substantially related to his more than 39 years of coal mine employment." (CX 1). Dr. Cohen also noted that the miner's 20 pack year smoking history may be significantly contributory to his obstructive pulmonary impairment.

Dr. Cohen stated that the miner's symptoms of worsening shortness of breath, cough and sputum production began while he was still and miner, pre-dating the onset of his cardiac disease. (CX 1).

In analyzing the pulmonary function study, Dr. Cohen found a "severe restrictive lung disease wit an additional mild obstructive component leading to a severely impaired FEV1." Dr. Cohen also noted a severe diffusion impairment. Dr. Cohen opined that the restrictive impairment resulted from interstitial lung disease "as seen in coal workers' pneumoconiosis." Dr. Cohen also explained that a component of the impairment is "also due to loss of lung volume from his cardiac failure, cardiomegaly, and resultant pleural disease." (CX 1).

Dr. Cohen concluded that Mr. Fudala's coal dust exposure and cigarette smoke exposure significantly contributed to his mild obstructive impairment. Dr. Cohen opined that the impairment disabled Mr. Fudala from his last coal mine employment. (CX 1).

Dr. Cohen was deposed on June 1, 2005. (CX 1). Dr. Cohen testified regarding the pulmonary function study performed during the May 25, 2004 examination. He stated that the pulmonary function study showed "a moderately severe reduction in his vital capacity, a severely reduced forced expiratory volume in one second, and a mildly reduced ratio of his FEV1 to his FVC." (CX 1; p. 12). He stated that the total lung capacity was moderately severely reduced and there was severe diffusion impairment with low normal diffusion corrected for alveolar volume. Dr. Cohen noted that the arterial blood gas study showed hypoxemia. (CX 1; p. 12). Dr. Cohen concluded "[M]y interpretation of this study was that it was a moderately severe restrictive defect, with an additional obstructive defect, leading to severe impairment of his FEV1." (CX 1; p. 12). Dr. Cohen repeated his conclusion that Mr. Fudala suffered from coal workers' pneumoconiosis. (CX 1; p. 13).

Dr. Cohen testified that Mr. Fudala had a restrictive impairment and an obstructive impairment. Dr. Cohen determined that the restrictive impairment was caused by the miner's interstitial lung disease from his coal dust exposure and his cardiac failure. Dr. Cohen attributed coal dust exposure and his cigarette smoke exposure to causing the obstructive impairment. (CX 1; pp. 13-14). Dr. Cohen explained that Mr. Fudala's substantial coal dust exposure was at least double his cigarette smoking exposure. (CX 1; p. 15). Dr. Cohen reiterated the conclusion in his report that Mr. Fudala's pneumoconiosis was a "significant contributory factor to that lung function impairment and to his pulmonary disability." (CX 1; p. 16).

Dr. Renn stated that the restrictive component in Mr. Fudala's pulmonary function study test was due solely to Mr. Fudala's cardiac problems. Dr. Cohen testified that he does not agree with Dr. Renn's conclusion. Dr. Cohen stated that he does not agree due to the fact that the miner had a very substantial diffusion impairment and due to the heavy coal mine dust exposure. (CX 1; p. 17).

Dr. Renn also stated that a pure restriction impairment cannot be caused by coal dust exposure. Dr. Cohen testified that "[I]t's well known that coal mine dust, if it results in mainly interstitial lung disease, will cause a pure restrictive impairment." (CX 1; p. 18). Dr. Cohen stated that coal mine dust can cause a restrictive impairment alone, an obstructive impairment alone, or a mixed pattern of both restriction and obstruction.

On cross-examination, Dr. Cohen testified that Mr. Fudala had a disabling heart disease. (CX 1; p. 24). Dr. Cohen noted, however, that his heart condition would not have caused his obstructive impairment.

Dr. Renn is a B-reader and Board-certified in internal medicine, pulmonary diseases and forensic medicine. He examined the miner on January 6, 2004. (DX 20). Dr. Renn stated that Frank Fudala communicated his symptoms as exertional dyspnea. He noted that Mr. Fudala had a cardiac pacemaker implanted in 2000. In 2000 and 2003, Dr. Renn notes that Mr. Fudala was hospitalized to remove fluid from his right hemithorax. His report notes a 30 plus years of coal mine employment. Dr. Renn noted that Mr. Fudala smoked a pack of cigarettes per day from 1943 until quitting in 1964. A serum nicotine level was taken during the examination. No nicotine was detected. (DX 20).

Dr. Renn describes his findings from an examination of the chest:

> His chest expands symmetrically. His lungs reveal a hyporesonant[16] percussion note and diminished tactile fremitus over the right hemithorax. Auscultation reveals bronchial breathing of the right posterior hemithorax. There are neither crackles nor wheezes. Examination of his left lung is entirely normal. There is 4+ ankle, 3+ right pretibial and 2+ left pretibial edema. There is no jugular venous distention, hepatojugular reflux, hepatomegaly, clubbing and cyanosis.

(DX 20). Dr. Renn also interpreted an X-ray taken during the examination. Dr. Renn states that the X-ray reveals "a large right pleural effusion, cardiomegaly, an atherosclerotic aorta and a cardiac pacemaker implant overlying the left mid zone." Dr. Renn found no plural or parenchymal abnormalities consistent with pneumoconiosis. (DX 20).

Dr. Renn also discussed the breathing tests performed. He stated that the spirometry is consistent with a severe restrictive ventilatory defect. But, he found that the lung volume study reveals a moderate restrictive ventilatory defect. (DX 20).

Based on arterial blood gases, a pulmonary function study, and a negative chest X-ray, Dr. Renn concluded that pneumoconiosis was not present. Dr. Renn diagnosed chronic biventricular cardiac failure, atherosclerotic cardiomyopathy and large right pleural effusion. Dr. Renn stated that none of the diagnoses were either caused, or contributed to, by the miner's exposure to coal mine dust. (DX 20).

Dr. Renn opined that Frank Fudala was totally and permanently impaired as a result of primary heart disease. (DX 20).

Dr. Renn was deposed on May 27, 2004. (EX 4). Dr. Renn discussed the findings of his examination. He stated that Mr. Fudala had diminished tactile fremitus, hyporesonant percussion note, and bronchial breathing of the right posterior hemithorax. Dr. Renn stated that these "three signs indicate that there was something between the lung and the chest wall." He explained that something was inducing a compression of the lung. (EX 4, p. 9).

Dr. Renn interpreted a chest X-ray as negative with a profusion of 0/0. He stated that the chest X-ray showed a large right pleural effusion, an enlarged heart, atherosclerotic aorta, and a heart pacemaker implant overlaying the left mid zone. (EX 4, p. 11).

Dr. Renn testified that Mr. Fudala did not suffer from medical nor legal pneumoconiosis. Dr. Renn explained that Mr. Fudala had a pure restrictive ventilatory defect with no obstruction. Dr. Renn stated "[R]estrictive ventilatory defects when they have been found in coal workers' pneumoconiosis are usually also in conjunction with an obstructive ventilatory defect, and he doesn't have any evidence that he has an obstructive ventilatory defect whatsoever." (EX 4, pp.

[16] The report states "hyperresonant percussion note." At his deposition, Dr. Renn testified that this was a typographical error. The correct term is hyporesonant.

12-13). Dr. Renn further explained that a restrictive defect related to coal workers' pneumoconiosis does not reduce to the extent it did in Mr. Fudala. (EX 4; p. 24).

Dr. Renn testified that he disagreed with Dr. Celko's finding of an obstructive ventilatory defect. Dr. Renn stated "[T]he spirometry study shows that he has a pattern consistent with a restrictive ventilatory defect and no pattern consistent with an obstructive ventilatory defect." (EX 4; p. 50).

Dr. Renn found that Mr. Fudala was totally disabled due to chronic biventricular cardiac failure. (EX 4; p. 15). Dr. Renn opined that Mr. Fudala's lungs were not impaired. He stated that his restrictive ventilatory defect was a result of chronic heart failure. (EX 4; p. 22). On cross-examination, Dr. Renn testified that Mr. Fudala's restrictive defect alone would have been sufficient to disable him from his last coal mine employment.

Dr. Renn testified that Mr. Fudala does not have a pulmonary impairment related to coal dust exposure or cigarette smoking. (EX 4, p. 23). Dr. Renn opined that any pulmonary impairment Mr. Fudala had was related to his heart disease and his pleural effusion. (EX 4; p. 44). Dr. Renn stated that Mr. Fudala needed oxygen for his heard disease, not for any pulmonary problems. (EX 4; p. 47).

Dr. Celko is Board-certified in internal medicine and specializes in pulmonary disease. Dr. Celko performed the Department of Labor examination of Frank Fudala on December 20, 2003. (DX 19). His report notes over 30 years of coal mine employment. Dr. Celko noted that the miner began smoking at age 19, but quit 40 years prior to the examination. (DX 19). Dr. Celko described the claimant's symptoms as dyspnea and ankle edema.

Based on arterial blood gases, a pulmonary function study, and a negative chest X-ray, Dr. Celko diagnosed Frank Fudala with chronic obstructive lung disease and congestive heart failure. He opined that the claimant's pulmonary condition was related to his coal dust exposure and cigarette consumption. (DX 19).

Dr. Celko determined that the miner was totally impaired from a cardiopulmonary standpoint. He stated that Frank Fudala was "totally disabled from cardiac as well as independently from a pulmonary standpoint." Dr. Celko further noted that the miner should be referred to another physician for further evaluation because he needs to use oxygen. (DX 19).

E. Death Certificate

Frank Fudala passed away on November 6, 2004. His death certificate was completed by Coroner Gregory P. Rohanna. Mr. Rohanna is not a medical doctor. Under "immediate cause" of death, Mr. Rohanna listed coronary artery disease and congestive heart failure. (DX 16).

III. Hospital Records & Physician Office Notes

Progress notes from the Centerville Clinic are included in evidence. (DX 18). The signature of the medical professional taking the notes is unreadable. On August 3, 2001, the

miner went to the clinic with shortness of breath. He was advised to go to the hospital, but he refused. The exhibit further contains pages of unreadable notes.

On May 1, 2002, an April 30, 2002 chest film was interpreted by Dr. Alcantara. Dr. Alcantara listed his impression as mild bilateral pulmonary congestion and moderate to large right sided free pleural effusion with minimal left sided free pleural effusion. (DX 18).

IV. Witness' Testimony

Thomas Fudala, the miner's son, testified at the hearing. (TR 10). Mr. Fudala testified that his father's last day of coal mine work was April 6, 1986. He stated that his father's last job title in the mines was mechanic.

Mr. Fudala testified that his father was having breathing problems while working at the mines. He stated that his father couldn't walk less than a block to get the newspaper. Mr. Fudala stated that Mr. Reddy prescribed his father oxygen approximately two years prior to his death. (TR 11). Mr. Fudala believed that his father was having heart problems for approximately twelve years. (TR 14).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Entitlement to Benefits

This claim must be adjudicated under the regulations at 20 C.F.R. Part 718 because it was filed after March 31, 1980. Under this Part, the claimant must establish, by a preponderance of the evidence, that: (1) he has pneumoconiosis; (2) his pneumoconiosis arose out of coal mine employment; and, (3) he is totally disabled due to pneumoconiosis. Failure to establish any one of these elements precludes entitlement to benefits. 20 C.F.R. §§ 718.202-718.205; *Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-112 (1989); *Trent v. Director, OWCP*, 11 B.L.R. 1-26 (1987); and *Perry v. Director, OWCP,* 9 B.L.R. 1-1 (1986). The claimant bears the burden of proving each element of the claim by a preponderance of the evidence, except insofar as a presumption may apply. *See Director, OWCP v. Mangifest*, 826 F.2d 1318, 1320 (3rd Cir. 1987). Failure to establish any of these elements precludes entitlement. *Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986). Moreover, "[T]he presence of evidence favorable to the claimant or even a tie in the proof will not suffice to meet that burden." *Eastover Mining Co. v. Director, OWCP [Williams]*, 338 F.3d 501, No. 01-4604 (6th Cir. July 31, 2003), *citing Greenwich Collieries [Ondecko]*, 512 U.S. 267 at 281; *see also Peabody Coal Co. v. Odom*, ___ F.3d ___, 2003 WL 21998333 (6th Cir. Aug. 25, 2003).

Since this is the claimant's second claim for benefits, and it was filed on or after January 19, 2001, it must be adjudicated under the new regulations.[17] Although the new regulations

[17] Section 725.309(d)(For duplicate claims filed on or after Jan. 19, 2001)(65 Fed. Reg. 80057 & 80067):

(d) If a claimant files a claim under this part more than one year after the effective date of a final order denying a claim previously filed by the claimant under this part (see § 725.502(a)(2)), the later claim shall be considered a subsequent claim for benefits. A subsequent claim shall be processed and adjudicated in accordance with the provisions of subpart E and F of this part, except that the claim shall be denied unless the claimant

dispense with the "material change in conditions" language of the older regulations, the criteria remain similar to the "one-element" standard set forth by the Sixth Circuit in *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994). In *Dempsey v. Sewell Coal Co. & Director, OWCP*, ___ B.L.R. ___, BRB Nos. 03-0615 BLA an d03-0615 BLA-A (June 28, 2004), the Board held that where a miner files a claim for benefits more than one year after the final denial of a previous claim, the subsequent claim must also be denied unless the administrative law judge finds that "one of the applicable conditions of entitlement…has changed since the date upon which the order denying the prior claim became final." 20 C.F.R. Section 725.309(d); *White v. New White Coal Co.*, *Inc.*, 23 B.L.R. 1-1, 1-3 (2004). According to the Board, the "applicable conditions of entitlement" are "those conditions upon which the prior denial was based." 20 C.F.R. Section 725.309(d)(2).

To assess whether a material change in conditions is established, the Administrative Law Judge must consider all of the new evidence, favorable and unfavorable, and determine whether the claimant has proven, at least one of the elements of entitlement previously adjudicated against him in the prior denial of December 2, 1986. *Lisa Lee Mines v. Director, OWCP [Rutter]*, 86 F.3d 1358 (4th Cir. 1996)(*en banc*) *rev'g* 57 F.3d 402 (4th Cir. 1995), *cert. den.*, 117 S.Ct. 763 (1997); *Sharondale Corp v. Ross*, 42 F.3d 993 (6th Cir. 1994); and *LaBelle Processing Co. v. Swarrow*, 72 F.3d 308, 20 B.L.R. 2-76 (3rd Cir. 1995). If the miner establishes the existence of that element, he has demonstrated, as a matter of law, a material change. The Administrative Law Judge must then consider whether all of the record evidence, including that submitted with the previous claim, supports a finding of entitlement to benefits. *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994) and *LaBelle Processing Co. v. Swarrow*, 72 F.3d 308 (3rd Cir. 1995).

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demonstrates that one of the applicable conditions of entitlement (see Section 725.202(d)(miner), 725.212(spouse), 725.218(child), and 725.222(parent, brother or sister)) has changed since the date upon which the order denying the prior claim became final. The applicability of this paragraph may be waived by the operator or fund, as appropriate. The following additional rules shall apply to the adjudication of a subsequent claim:

(1) any evidence submitted in connection with any prior claim shall be made a part of the record in the subsequent claim, provided that it was not excluded in the adjudication of the prior claim.

(2) For purposes of this section, the applicable conditions of entitlement shall be limited to those conditions upon which the prior denial was based. For example, if the claim was denied solely on the basis that he individual was not a miner, the subsequent claim must be denied unless the individual worked as a miner following the prior denial. Similarly, if the claim was denied because the miner did not meet one or more of the eligibility criteria contained in part 718 of this subchapter, the subsequent claim must be denied unless the miner meets at least one of the criteria that he or she did not meet previously.

(3) If the applicable condition(s) of entitlement relate to the miner's physical condition, the subsequent claim may be approved only if new evidence submitted in connection with the subsequent claim establishes at least one applicable condition of entitlement. A subsequent claim filed by a surviving spouse, child, parent, brother, or sister shall be denied unless the applicable conditions of entitlement in such claim include at least one condition unrelated to the miner's physical condition at the time of his death.

(4) If the claimant demonstrates a change in one of the applicable conditions of entitlement, no findings made in connection with the prior claim, except those based on a party's failure to contest an issue (see §725.463), shall be binding on any party in the adjudication of the subsequent claim. However, any stipulation made by any party in connection with the prior claim shall be binding on that party in the adjudication of the subsequent claim.

(5) In any case in which a subsequent claim is awarded, no benefits may be paid for any period prior to the date upon which the order denying the prior claim became final.

In *Caudill v. Arch of Kentucky, Inc.*, 22 B.R.B. 1-97, BRB No. 98-1502 (Sept. 29, 2000)(*en banc on recon.)*, the Benefits Review Board held the "material change" standard of section 725.309 "requires an adverse finding on an element of entitlement because it is necessary to establish a baseline from which to gauge whether a material change in conditions has occurred." Unless an element has previously been adjudicated against a claimant, "new evidence cannot establish that a miner's condition has changed with respect to that element." Thus, in a claim where the previous denial only adjudicated the matter of the existence of the disease, the issue of total disability "may not be considered in determining whether the newly submitted evidence is sufficient to establish a material change in conditions…"

The claimant's first application for benefits was denied because the evidence failed to show that: (1) the claimant had pneumoconiosis; (2) the pneumoconiosis arose, at least in part, out of coal mine employment; and (3) the claimant was totally disabled by pneumoconiosis. (DX 1). Under the *Sharondale* standard, the claimant must show the existence of one of these elements by way of newly submitted medical evidence in order to show that a material change in condition has occurred. If he can show that a material change has occurred, then the entire record must be considered in determining whether he is entitled to benefits.

The deceased miner's first claim for benefits was denied because he did not prove, by a preponderance of the evidence, that he had coal workers' pneumoconiosis or that he was totally disabled due to coal workers' pneumoconiosis. As discussed below, I find that the miner has proven by newly submitted evidence that he had coal workers' pneumoconiosis. As such, the miner has proven a material change in conditions since the prior denial of benefits.

B. Existence of Pneumoconiosis

Pneumoconiosis is defined as a "chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." 30 U.S.C. § 902(b) and 20 C.F.R. § 718.201. The definition is not confined to "coal workers' pneumoconiosis," but also includes other diseases arising out of coal mine employment, such as anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, progressive massive fibrosis, silicosis, or silicotuberculosis. 20 C.F.R § 718.201.[18]

[18] Regulatory amendments, effective January 19, 2001, state:

(a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis,

(1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.

(2) Legal Pneumoconiosis. "Legal Pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

The term "arising out of coal mine employment" is defined as including "any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment."[19] Thus, "pneumoconiosis", as defined by the Act, has a much broader legal meaning than does the medical definition.

"…[T]his broad definition 'effectively allows for the compensation of miners suffering from a variety of respiratory problems that may bear a relationship to their employment in the coal mines.'" *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, 14 B.L.R. 2-68 (4th Cir. 1990) at 2-78, 914 F.2d 35 (4th Cir. 1990) *citing Rose v. Clinchfield Coal Co.*, 614 F.2d 936, 938 (4th Cir. 1980).

Thus, asthma, asthmatic bronchitis, or emphysema may fall under the regulatory definition of pneumoconiosis, if they are related to coal dust exposure. *Robinson v. Director, OWCP*, 14 B.L.R. 1-798.7 (1981); *Tokarcik v. Consolidation Coal Co.*, 6 B.L.R. 1-666 (1983). Likewise, chronic obstructive pulmonary disease may be encompassed within the legal definition of pneumoconiosis. *Warth v. Southern Ohio Coal Co.*, 60 F.3d 173 (4th Cir. 1995) and *see* § 718.201(a)(2).

The claimant has the burden of proving the existence of pneumoconiosis. The Regulations provide the means of establishing the existence of pneumoconiosis by: (1) a chest X-ray meeting the criteria set forth in 20 C.F.R. § 718.202(a)(1); (2) a biopsy or autopsy conducted and reported in compliance with 20 C.F.R. § 718.106; (3) application of the irrebutable presumption for "complicated pneumoconiosis" found in 20 C.F.R. § 718.304; or (4) a determination of the existence of pneumoconiosis made by a physician exercising sound judgment, based upon certain clinical data and medical and work histories, and supported by a reasoned medical opinion.[20] 20 C.F.R. § 718.202(a)(4).

The Third Circuit has held that the four methods of establishing the existence of the disease, provided in 20 C.F.R. § 718.202, are not to be considered in the disjunctive; that is, relevant evidence developed under the four methods of proof are to be considered together to determine whether a claimant has pneumoconiosis. *Penn Allegheny Coal Co. v. Williams &*

(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.
(Emphasis added).

[19] The definition of pneumoconiosis, in 20 C.F.R. section 718.5201, does not contain a requirement that "coal dust specific diseases…attain the status of an "impairment" to be so classified. The definition is satisfied "whenever one of these diseases is present in the miner at a detectable level; whether or not the particular disease exists to such an extent as to become compensable is a separate question." Moreover, the legal definition of pneumoconiosis "encompasses a wide variety of conditions; among those are disease whose etiology is not the inhalation of coal dust, but whose respiratory and pulmonary symptomatology have nevertheless been made worse by coal dust exposure. *See e.g., Warth*, 60 F.3d at 175." *Clinchfield Coal v. Fuller*, 180 F.3d 622 (4th Cir. June 25, 1999) at 625.

[20] In accordance with the Board's guidance, I find each medical opinion documented and reasoned, unless otherwise noted. *Collins v. J & L Steel,* 21 B.L.R. 1-182 (1999) *citing Trumbo v. Reading Anthracite Co.*, 17 B.L.R. 1-85 (1993); *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987); and, *Sterling Smokeless Coal Co. v. Akers*, 121 F.3d 438, 21 B..R. 2-269 (4th Cir. 1997). This is the case, because except as otherwise noted, they are "documented" (medical), i.e., the reports set forth the clinical findings, observations, facts, etc., on which the doctor has based his diagnosis and "reasoned" since the documentation supports the doctor's assessment of the miner's health.

Director, OWCP, 114 F.3d 22 (3rd Cir. June 3, 1997) *citing* 30 U.S.C. § 923(b) and *Kertesz v. Crescent Hills Coal Co.*, 788 F.2d 158 (3rd Cir. 1986).

The claimant cannot establish pneumoconiosis pursuant to subsection 718.202(a)(2) because there is no biopsy evidence in the record. The claimant cannot establish pneumoconiosis under § 718.202(a)(3), as none of that sections presumptions are applicable to a living miner's claim filed after January 1, 1982, with no evidence of complicated pneumoconiosis.

A finding of the existence of pneumoconiosis may be made with positive chest X-ray evidence. 20 C.F.R. § 718.202(a)(1). The correlation between "physiologic and radiographic abnormalities is poor" in cases involving CWP. "[W]here two or more X-ray reports are in conflict, in evaluating such X-ray reports, consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays." *Id.*; *Dixon v. North Camp Coal Co.*, 8 B.L.R. 1-344 (1985)." (Emphasis added). (Fact one is Board-certified in internal medicine or highly published is not so equated). *Melnick v. Consolidation Coal Co. & Director, OWCP*, 16 B.L.R. 1-31 91991) at 1-37. Readers who are Board-certified radiologists and/or B-readers are classified as the most qualified. The qualifications of a certified radiologist are at least comparable to if not superior to a physician certified as a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-231, n.5 (1985).

A judge is not required to defer to the numerical superiority of X-ray evidence, although it is within his or her discretion to do so. *Wilt v. Wolverine Mining Co.*, 14 B.L.R. 1-70 (1990) citing *Edmiston v. F & R Coal*, 14 B.L.R. 1-65 (1990).

The May 27, 2004 X-ray is the most recent X-ray interpretation in the record. A dually-qualified physician interpreted the X-ray as positive for coal workers' pneumoconiosis. There are no other interpretations of this X-ray in the record. As such, I find that the most recent X-ray is positive for coal workers' pneumoconiosis.

A May 25, 2004 X-ray was interpreted by an experienced B-reader as positive for coal workers' pneumoconiosis. Again this is the only interpretation of the May 25, 2004 X-ray. As there is no conflicting evidence, I find the May 25, 2004 X-ray is positive for coal workers' pneumoconiosis.

A B-reader interpreted a January 6, 2004 X-ray as showing no abnormalities consistent with coal workers' pneumoconiosis. No other readings of this X-ray are included in evidence. As such, I find the January 6, 2004 X-ray is negative for coal workers' pneumoconiosis.

The record contains multiple interpretations of an October 20, 2003 X-ray. Two dually-qualified physicians interpreted the X-ray as positive for coal workers' pneumoconiosis. Both interpretations noted a 1/1 profusion. Additionally, another dually-qualified physician interpreted the X-ray as showing no abnormalities consistent with pneumoconiosis. The physicians interpreting the X-ray are equally qualified. Based on a majority of the readings being positive, I find that the X-ray is positive for coal workers' pneumoconiosis. I also find, however, that the October 20, 2003 X-ray is entitled to the least weight of all the X-rays submitted in the current claim, due to the fact that a quality-only reading by a dually-qualified physician found the X-ray to be of poor quality.

The current claim also includes an X-ray dated January 29, 2003. This X-ray was interpreted as positive for coal workers' pneumoconiosis by two dually-qualified physicians. There are no conflicting interpretations of this X-ray in the record. Therefore, I find the January 29, 2003 X-ray is positive for coal workers' pneumoconiosis.

In summary, I find the May 27, 2004, May 25, 2004 and January 29, 2003 chest X-rays positive for coal workers' pneumoconiosis. I also find the October 20, 2003 X-ray positive for coal workers' pneumoconiosis, but accord less weight to this X-ray than the other X-rays in the record. I find the January 6, 2004 X-ray negative for coal workers' pneumoconiosis. Therefore, based on a majority of the X-rays being positive for coal workers' pneumoconiosis, I find that the X-ray evidence submitted in the current claim is evidence of coal workers' pneumoconiosis.

A determination of the existence of pneumoconiosis can be made if a physician, exercising sound medical judgment, based upon certain clinical data, medical and work histories and supported by a reasoned medical opinion, finds the miner suffers or suffered from pneumoconiosis, as defined in § 718.201, notwithstanding a negative X-ray, 20 C.F.R. § 718.202(a).

Medical reports which are based upon and supported by patient histories, a review of symptoms, and a physical examination constitute adequately documented medical opinions as contemplated by the Regulations. *Justice v. Director, OWCP*, 6 B.L.R. 1-1127 (1984). However, where the physician's report, although documented, fails to explain how the documentation supports its conclusions, an Administrative Law Judge may find the report is not a reasoned medical opinion. *Smith v. Eastern Coal Co.*, 6 B.L.R. 1-1130 (1984). A medical opinion shall not be considered sufficiently reasoned if the underlying objective medical data contradicts it. *White v. Director, OWCP*, 6 B.L.R. 1-368 (1983).

Physician's qualifications are relevant in assessing the respective probative value to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597 (1984). Because of their various Board-certifications, B-reader status, and expertise, as noted above, I rank Drs. Fino, Cohen, Celko and Renn slightly above Drs. Garson and Reddy.

While the courts and the Board earlier recognized that there may be a practical distinction between a physician who merely examines a miner and one who is one of his "treating" physicians, that preference has largely been obviated, except in the Third Circuit.[21] Dr. Reddy

[21] "Treatment" means "the management and care of a patient for the purpose of combating disease or disorder." DORLAND'S ILLUSTRATED MEDICAL DICTIONARY, p. 1736 (28th Ed. 1994). "Examination" means "inspection, palpitation, auscultation, percussion, or other means of investigation, especially for diagnosing disease, qualified according to the methods employed, as physical examination, radiological examination, diagnostic imaging examination, or cystoscopic examination." DORLAND'S ILLUSTRATED MEDICAL DICTIONARY, p. 589 (28th Ed. 1994). *Onderko v. Director, OWCP,* 14 B.L.R. 1-2 (1989); *Jones v. Badger Coal Co.*, 21 B.L.A. 1-102, BRB No. 97-1393 BLA (Nov. 30, 1998)(*en banc*)(Proper for Judge to accord greater weight to treating physician over non-examining doctors). In *Soubik v. Director, OWCP*, ___ F.3d ___, Case No. 03-1668, 23 B.L.R. 2-85 (3rd Cir. April 30, 2004), citing *Mancia v. Director, OWCP*, 130 F.3d 579, 590-591 (3rd Cir. 1997), the court reiterated that "It is well-established in this Circuit that treating physician's opinions are assumed to be more valuable than those of non-treating physicians. *Lango v. Director, OWCP,* 104 F.3d 573 (3rd Cir. 1997). The Court wrote that while there is "some question about the extent of reliance to be given a treating physician's opinion when there is conflicting evidence, *compare Brown v. Rock Creek Mining Co.*, 996 F.2d 812, 816 (6th Cir. 1993)(opinions of treating

was Mr. Fudala's treating physician for two years. As such, his opinion must be considered under the criteria of section 718.104(d).[22]

Although Dr. Reddy was the miner's treating physician, I find that two years of treatment is not sufficient to warrant controlling or special consideration to Dr. Reddy's opinion merely due to the status of treating physician. His examination of the miner on 16 separate occasions adds value and credit to his opinion. But, such relationship will not be used to accord his opinion controlling weight.

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physicians are clearly entitled to greater weight than those of non-treating physicians)," a judge may require "the treating physician to provide more than a conclusory statement (before finding pneumoconiosis contributed to the miner's death)."*But se, Sterling Smokeless Coal Co. v. Akers,* 131 F. 3d 438, 21 B.L.R. 2-269 (4th Cir. 1997), wherein the court held that a rule of absolute deference to treating and examining physicians is contrary to its precedents. *See also, Amax Coal Co. v. Franklin*, 957 F.2d 355 (7th Cir. 1992) where the court criticized the administrative law judge's crediting of a treating general practitioner, with no apparent knowledge of CWP and no showing that his ability to observe the claimant over an extended time period was essential to understanding the disease, over an examining Board-certified pulmonary specialist bordered on the irrational. The court called judge's deference to the "treating physician" over a non-treating specialist unwarranted in light of decisions such as *Richardson v. Perales,* 402 U.S. 389, 91 S.Ct. 1420, 28 L.Ed.2d 842 (1971); *Garrison v. Heckler*, 765 F.3d 710, 713-15 (7th Cir. 1985); and, *DeFrancesco v. Bowen*, 867 f.2d 1040, 1043 (1989). *Consolidation Coal Co. v. Director, OWCP [Held]*, ___ F.3d __, Case No. 99-2507 (4th Cir. Dec. 20, 2000)(with Dissent). Improper to accord greater weight to the opinion of treating physician because he had treated and examined claimant each year over the past ten years. In *Grizzle v. Pickland Mather & Co.*, 994 F.2d 1093 (4th Cir. 1993), we clearly stated we had not fashioned any presumption or requirement that the treating physicians' opinions be given greater weight. While the treating physician's opinion here may have been entitled to "special consideration", it was not entitled to the greater weight accorded. In *Eastover Mining Co. v. Director, OWCP [Williams]*, 338 F.3d 501, No. 01-4064 (6th Cir. July 31, 2003), the Court made clear its view that no deference is given to treating physicians merely because of their status as the same. It pointed out, citing *Black & Decker Disability Plan v. Nord*, 123 S.Ct. at 1969, 1971, the Supreme Court itself has "disapproved of the 'treating physician rule' with language that criticizes the principle itself, rather than its operation in an ERISA context."

[22] § 718.104(d) Treating Physician (Jan. 19, 2001). In weight the medical evidence of record relevant to whether the miner suffers, or suffered, from pneumoconiosis arose out of coal mine employment, and whether the miner is, or was totally disabled by pneumoconiosis or died due to pneumoconiosis, the adjudication officer must give consideration to the relationship between the miner and any treating physician whose report is admitted into the record. Specifically, the adjudication officer shall take into consideration the following factors in weighing the opinion of the miner's treating physician:

(1) Nature of relationship. The opinion of a physician who has treated the miner for respiratory or pulmonary conditions is entitled to more weight than a physician who has treated the miner for non-respiratory conditions;

(2) Duration of relationship. The length of the treatment relationship demonstrated whether the physician has observed the miner long enough to obtain a superior understanding of his or her condition;

(3) Frequency of treatment. The frequency of physician-patient visits demonstrates whether the physician has observed the miner often enough to obtain a superior understanding of his or her condition; and

(4) Extent of treatment. The types of testing and examinations conducted during the treatment relationship demonstrate whether the physician has obtained superior and relevant information concerning the miner's condition.

(5) In the absence of contrary probative evidence, the adjudication office shall accept the statement of a physician with regard to the factors listed in paragraphs (d)(1) through (4) of this section. In appropriate cases, the relationship between the miner and his treating physician may constitute substantial evidence in support of the adjudication officers' decision to give the physician's opinion controlling weight, provided that the weight given to the opinion of a miner's treating physician shall also be based on the credibility of the physician's opinion in light of its reasonings and documentation, other relevant evidence and the record as a whole.

Dr. Reddy diagnosed Mr. Fudala with coal workers' pneumoconiosis. Dr. Reddy noted that Mr. Fudala had a significant and severe pulmonary defect. As part of his treatment of Mr. Fudala, Dr. Reddy prescribed him oxygen to use as needed.

Dr. Reddy's opinion notes a coal dust exposure history and smoking history consistent with my findings. Dr. Reddy found his coal dust exposure to be significant and substantial. He stated that the coal dust exposure was far greater than the miner's smoking exposure. Thus, although he stated that the cigarette smoking exposure had a part in the miner's pulmonary impairment, the coal dust exposure was the significant contributing factor.

As discussed above, Mr. Fudala was also diagnosed by various doctors with cardiomyopathy. Dr. Reddy also acknowledged the miner's cardiac problems. He stated that his cardiac problems played an additional role in the miner's impairment. But, his shortness of breath began prior to his heart condition.

I find that Dr. Reddy adequately addressed all aspects of Mr. Fudala's condition. I also find that he provided a detailed and well-explained opinion of his examinations of Mr. Fudala.

Dr. Fino provided an opinion based upon his review of the miner's medical records. Dr. Fino is a highly qualified physician with many years of experience in reviewing medical reports regarding coal workers' pneumoconiosis. Dr. Fino accurately noted Mr. Fudala's coal mine work and his smoking history. Dr. Fino opined that it is totally unreasonable to find that coal dust exposure caused Mr. Fudala's respiratory impairment. Dr. Fino found that Mr. Fudala's respiratory impairment was caused by severe cardiomyopathy.

In his report, Dr. Fino provides a chart of the chest X-rays he reviewed. This chart includes five X-rays that were interpreted as positive for coal workers' pneumoconiosis. Dr. Fino provided no explanation as to why he disagrees with these findings. He merely states "[T]he chest X-ray interpretations have shown an enlarged heart with a large pleural effusion." The physicians of record agree that Mr. Fudala had a heart condition. The issue is whether, in addition to a heart condition, Mr. Fudala had coal workers' pneumoconiosis. Dr. Fino provides no explanation as to why Mr. Fudala could not have had both coal workers' pneumoconiosis and cardiomyopathy. He provides no explanation as to why he disagrees with the chest X-ray interpretations by dually-qualified physicians. Dr. Fino merely summarizes the chest X-ray evidence in a chart without addressing how such evidence relates to his conclusion that the miner did not have coal workers' pneumoconiosis.

Dr. Fino's report notes that a 1986 pulmonary function study produced normal results. Dr. Fino stated "[T]his clearly and unequivocally shows that two years after he left the mines and over 20 years after he stopped smoking, his lung function was unequivocally normal." (EX 1). It is well established that pneumoconiosis is a progressive and irreversible disease. Dr. Fino's reliance on a 1986 test, when results of 2002 and 2004 tests were available, ignores the progressive nature of the disease.

I find that Dr. Fino's report did not adequately explain how the objective evidence supports a finding that Mr. Fudala did not have coal workers' pneumoconiosis. As such, I find

that Dr. Reddy's explanation of his findings after examining the miner is entitled to more weight than Dr. Fino's report reviewing the medical evidence.

Dr. Garson examined the miner on two separate occasions. He diagnosed Mr. Fudala with coal workers' pneumoconiosis. Dr. Garson, consistent with the other physicians of record, noted that, in addition to coal workers' pneumoconiosis, Mr. Fudala had heart disease. Dr. Garson also noted the miner's diabetes.

Dr. Garson found pneumoconiosis based on the miner's symptoms, chest X-ray and insignificant response to bronchodilators during a pulmonary function study. As pneumoconiosis is an irreversible disease, a miner's non-response to bronchodilators is another indication of the disease's presence. Dr. Garson stated that the miner's smoking history was so remote that it is not the cause of his pulmonary disease.

I find that Dr. Garson provided a reasoned opinion based upon his examinations of the miner. Dr. Garson effectively explained the findings of tests performed during his examination. In addition, his opinion is supported by the other objective evidence of record. As such, I find that his opinion is entitled to more weight than Dr. Fino's opinion.

Dr. Cohen examined Mr. Fudala and reviewed the medical records. Dr. Cohen diagnosed Mr. Fudala with coal workers' pneumoconiosis. In addition to his diagnosis of pneumoconiosis, Dr. Cohen noted that the miner had a history of diabetes and heart disease. Dr. Cohen's notations regarding coal dust exposure and smoking history are consistent with my findings.

Dr. Cohen based his diagnosis upon a chest X-ray and the objective evidence. He explained that the miner's restrictive impairment resulted from interstitial lung disease consistent with findings of pneumoconiosis. Dr. Cohen also found a mild obstructive impairment, which he attributed to coal workers' pneumoconiosis. He also stated that the miner's smoking history caused the obstructive impairment. But, he went on to explain that the coal dust exposure at least doubled his smoking exposure. Dr. Cohen stated that the miner's symptom of shortness of breath pre-dated his onset of heart disease.

Dr. Cohen is a well qualified and experienced physician in the area of pulmonary diseases. I find that Dr. Cohen provided a well reasoned and descriptive explanation of Mr. Fudala's pulmonary condition. I also find that his opinion is amply supported by the objective evidence of record. As such, based on his detailed opinion and qualifications, I find that Dr. Cohen's opinion is entitled to the most weight.

Dr. Renn, also well qualified, examined Mr. Fudala. Dr. Renn concluded that Mr. Fudala did not suffer from coal workers' pneumoconiosis. Dr. Renn diagnosed Mr. Fudala with cardiomyopathy. The cardiomyopathy diagnosis is consistent with the medical records in evidence.

Dr. Renn, although noting 30 plus years of coal mine employment, opined that none of the miner's conditions were caused by coal dust exposure. Dr. Renn appears to rest his finding on the fact that he found a restrictive defect with no obstruction. Dr. Renn, in conflict with Dr. Cohen, states that a restrictive defect is found in coal workers' pneumoconiosis only when an obstructive defect is also present.

I find that Dr. Renn provided a reasoned opinion based on the evidence provided at his examination of the miner. As such, I find that his opinion is entitled to greater weight than Dr. Fino's opinion.

Dr. Celko examined the miner for the Department of Labor. Based upon his examination of the miner, Dr. Celko diagnosed chronic obstructive lung disease and congestive heart failure.

Dr. Celko determined that the chest X-ray taken during the examination was negative for pneumoconiosis. Dr. Celko, however, concluded that the miner's chronic obstructive lung disease was related to his coal dust exposure and his cigarette consumption. This diagnosis supports a finding of legal pneumoconiosis.

I find that Dr. Celko provided a reasoned opinion of the objective evidence taken during his examination of the miner. I also find, however, that he did not provide a detailed explanation of his opinion. As such, I find that the opinions of Drs. Reddy, Garson, Cohen and Renn are entitled to more weight than the opinion of Dr. Celko.

In summary, Drs. Reddy, Garson, Cohen and Celko diagnosed Mr. Fudala with coal workers' pneumoconiosis. Drs. Fino and Renn determined that Mr. Fudala did not have coal workers' pneumoconiosis. As noted above, I find that Dr. Cohen's opinion is entitled to the most weight. I also find that Drs. Reddy, Garson, Cohen, Renn and Celko provided reasoned opinions. I find Dr. Fino's opinion to be entitled to the least weight. As such, based on these findings, I find that the physicians' opinions of record support a finding of coal workers' pneumoconiosis.

After reviewing the chest X-ray evidence and the physician opinions, I find that the Claimant has proven by a preponderance of the newly submitted evidence that the Mr. Fudala had coal workers' pneumoconiosis. Thus, as noted above, the claimant has proven a material change in condition since the prior denial.

As a general rule, more weight is given to the most recent evidence because pneumoconiosis is a progressive and irreversible disease. *Stanford v. Director, OWCP*, 7 B.L.R. 1-541 (1984); *Tokarcik v. Consolidated Coal Co.*, 6 B.L.R. 1-166 (1983); and *Call v. Director, OWCP*, 2 B.L.R. 1-146 (1979). This rule is not to be mechanically applied to require that later evidence be accepted over earlier evidence. *Burns v. Director, OWCP*, 7 B.L.R. 1-597 (1984).

The miner's first claim for benefits included an opinion by Dr. Yong Dae Cho. Dr. Cho did not diagnose Mr. Fudala with coal workers' pneumoconiosis. He found evidence of hypoxia and hypertension. The first claim also included a chest X-ray interpreted by a dually-qualified physician as negative for pneumoconiosis. As the evidence from the prior claim is twenty years old, I find that the evidence submitted in the current claim is more probative of the miner's condition at his death.

After reviewing the evidence submitted in the miner's first claim for benefits and the current claim for benefits, I find the Claimant has met his burden of proof in establishing the existence of pneumoconiosis. *Director, OWCP v. Greenwich Collieries*, 512 U.S. 267, 114 S.Ct. 2251, 129 L.Ed.2d 221 (1994) *aff'g sub. Nom. Greenwich Collieries v. Director, OWCP*, 990 F.2d 730, 17 B.L.R. 2-64 (3rd Cir. 1993).

C. Cause of Pneumoconiosis

Once the miner is found to have pneumoconiosis, he must show that it arose, at least in part, out of coal mine employment. 20 C.F.R. § 718.203(a). If a miner who is suffering from pneumoconiosis was employed for ten years or more in the coal mines, there is a rebuttable presumption that the pneumoconiosis arose out of such employment. 20 C.F.R. § 718.203(b). If a miner who is suffering or suffered from pneumoconiosis was employed less than ten years in the nation's coal mines, it shall be determined that such pneumoconiosis arose out of coal mine employment only if competent evidence establishes such a relationship. 20 C.F.R. § 718.203(c).

Since the miner had ten years or more of coal mine employment, he receives the rebuttable presumption that his pneumoconiosis arose out of coal mine employment. Nor does the record contain contrary evidence that establishes the claimant's pneumoconiosis arose out of alternative causes.

D. Cause of total disability

The revised regulations, 20 C.F.R. § 718.204(c)(1)[23], requires a claimant to establish his pneumoconiosis is a "substantially contributing cause" of his totally disabling respiratory or pulmonary disability.[24] The January 19, 2001 changes to 20 C.F.R. § 718.204(c)(1)(i) and (ii), adding the words "material" and "materially", results in "evidence that pneumoconiosis makes only a negligible, inconsequential, or insignificant contribution to the miner's total disability is insufficient to establish that pneumoconiosis is a substantially contributing cause of that disability." 65 Fed. Reg. No. 245, 7999946 (Dec. 20, 2000).[25]

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[23] *Gross v. Dominion Coal Corp*., 23 B.L.R. 1-8, BRB No. 03-0118 (2003). "'The substantially contributing cause' standard of revised Section 718.204(c) was not intended to alter the meaning of 'total disability due to pneumoconiosis' as previously determined in decisions by the various United States Courts of Appeal under Part 718, but rather was intended to codify the courts' decisions. 65 Fed. Reg. at 79946-47. Pneumoconiosis must be a necessary condition of the claimant's disability in that it cannot play a merely de minimis role. *Dehue Coal Co. v. Ballard*, 65 F.3d 1189, 1196 n. 8, 19 B.L.R. 2-304, 2-320 n.8 (4th Cir. 1995)." (Fn 10, at 1-18) "Consequently, the revised regulation requires that the adverse effect of pneumoconiosis be 'material.'"

[24] This standard is more consistent with the Third Circuit's pre-amendment "substantial contributor" standard set forth in *Bonessa v. U.S. Steel Corp.*, 884 F.2d 726, 13 B.L.R. 2-23 (3rd Cir. 1989) than the Fourth Circuit's "contributing cause" standard set forth in *Robinson v. Picklands Mather & Co./Leslie Coal Co. & Director, OWCP*, 14 B.L.R. 2-68 at 2-76, 914 F.2d 35, 38 (4th Cir. 1990). In *Gross v. Dominion Coal Corp.*, 23 B.L.R. 1-8, BRB No. 03-0118 (2003), the Board observed that "[U]nder the existing law of the Fourth Circuit, claimant is not required to establish relative degrees of causal contribution by pneumoconiosis and smoking to demonstrate that his total disability is due to pneumoconiosis. *See Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, 14 B.L.R. 2-68 at 2-76, 914 F.2d 35 (CA4 1990)(holding that a claimant must prove that pneumoconiosis is at least a contributing cause of total disability). Pneumoconiosis must be a necessary condition of the claimant's disability in that it cannot play a *de minimis* role. *Dehue Coal Co. v. Ballard*, 65 "F.3d 1189, 1196 n.8, 19 B.L.R. 2-304, 2-320 n.8 (4th Cir. 1995)."

[25] Effective January 19, 2001, § 718.204(a) states, in pertinent part:

> For purposes of this section, any nonpulmonary or nonrespiratory condition or disease, which causes an independent disability unrelated to the miner's pulmonary or respiratory disability, shall not be considered in determining whether a miner is totally disabled due to pneumoconiosis. If, however, a nonpulmonary or nonrespiratory condition or disease causes a chronic respiratory or pulmonary impairment, that condition or disease shall be considered in determining whether the miner is or was totally disabled due to pneumoconiosis.

The Board requires that pneumoconiosis be a "contributing cause" of the miner's disability. *Scott v. Mason Coal Co.*, 14 B.L.R. 1-37 (1990)(*en banc*), *overruling Wilburn v. Director, OWCP*, 11 B.L.R. 1-135 (1988).

The Third Circuit requires pneumoconiosis be a "substantial contributor" to the miner's total disability. *Bonessa v. U.S. Steel Corp.*, 884 F.2d 726, 734, 13 B.L.R. 2-23 (3rd Cir. 1989).

"A claimant must be totally disabled due to pneumoconiosis and any other respiratory or pulmonary disease, not due to other non-respiratory or non-pulmonary ailments, in order to qualify for benefits." *Beatty v. Danri Corp. & Triangle Enterprises,* 16 B.L.R. 1-11 (1991) *aff'd* 49 F.3d 993 (3rd Cir. 1995) *accord Jewell Smokeless Coal Corp.* (So, one whose disability is only 10% attributable to pneumoconiosis would be unable to recover benefits if his completely unrelated physical problems (i.e. stroke) created 90% of his total disability).

Proper for judge to accord less weight to physicians' opinions which found that pneumoconiosis did not contribute to the miner's disability on the grounds that the physicians did not diagnose pneumoconiosis. *Osborne v. Westmoreland Coal Co.*, __ B.L.R. __, BRB No. 96-1523 BLA (April 30, 1998).

There is evidence of record that claimant's respiratory disability is due, in part, to his undisputed history of cigarette smoking. However, to qualify for Black Lung benefits, the claimant need not prove that pneumoconiosis is the "sole" or "direct" cause of his respiratory disability, but rather that it has contributed to his disability. *Robinson v. Pickands Mather & Co./Leslie Coal Co. & Director, OWCP*, 914 F.2d 35, 14 B.L.R. 2-68 (4th Cir. 1990) at 2-76. *Jones v. Badger Coal Co.*, 21B.L.R. 1-102, BRB No. 97-1393 BLA (Nov. 30, 1998)(*en banc*). There is no requirement that doctors "specifically apportion the effects of the miner's smoking and his dust exposure in coal mine employment upon the miner's condition." *Jones v. Badger Coal Co.*, 21 B.L.R. 1-102, BRB No. 97-1393 BLA (Nov. 30, 1998)(*en banc*) *citing generally, Gorzalka v. Big Horn Coal Co.*, 16 B.L.R. 1-48 (1990).

As previously discussed, Drs. Fino and Renn concluded that the miner did not have medical or legal coal workers' pneumoconiosis. Both Doctors agreed that the miner was totally disabled from coal mine employment. As I have found that the miner had coal workers' pneumoconiosis, the opinions of Drs. Fino and Renn regarding the cause of the miner's disability are of little probative value.

Dr. Reddy, the miner's treating physician, concluded that the miner's coal dust exposure was a "significant contributing factor" in his pulmonary disability. Dr. Reddy also determined that the miner's cigarette smoking and heart disease played a role in the disability.

Dr. Garson also determined that the miner's pneumoconiosis was a "substantial contributing" factor in his pulmonary disability.

Dr. Cohen stated in his report and at a deposition that pneumoconiosis was a "significant contributing factor" to the miner's pulmonary disease. He also noted that smoking and heart disease caused impairment.

Dr. Celko found that the miner was totally disabled from a cardiac standpoint and independently from a pulmonary standpoint. He stated that the miner's pulmonary condition was related to his coal dust exposure and cigarette smoking.

As previously stated, I find that Drs. Reddy, Garson, Cohen and Celko provided reasoned opinions regarding the diagnosis of coal workers' pneumoconiosis. I also find that they provided reasoned opinions regarding the cause of the miner's disability. The four doctors of record that diagnosed Mr. Fudala with coal workers' pneumoconiosis also determined that he was totally disabled due to pneumoconiosis. Thus, based on those four physician opinions and the opinions of Drs. Fino and Renn, whose opinions regarding the issue of causation of disability are entitled to little weight, I find that the claimant has proven by a preponderance of the newly submitted evidence that the miner's total pulmonary disability was caused by coal workers' pneumoconiosis.

Dr. Cho examined the miner as part of his first claim for black lung benefits. Dr. Cho concluded that the miner did not have pneumoconiosis and that he was not totally disability. Based on the fact that Dr. Cho did not diagnosis coal workers' pneumoconiosis and that his opinion is twenty years old, I find his opinion of no probative value.

Thus, after reviewing all of the evidence, I find that the physicians of record whom diagnosed coal workers' pneumoconiosis agree that the pneumoconiosis was a substantial contributor of the miner's total pulmonary disability. Therefore, I find that the claimant proved by a preponderance of the evidence that coal workers' pneumoconiosis caused the miner's disability.

E. Date of Entitlement[26]

Benefits are payable beginning with the month of the onset of total disability due to pneumoconiosis.[27] 20 C.F.R. § 725.503. The miner is entitled to benefits as of June, 2003, the date the miner filed the current claim for benefits. Because no specific onset date of disability is evident from the record, benefits will begin on the first day of the month in which he filed this claim. 20 C.F.R. § 725.503(b).[28]

ATTORNEY FEES

[26] 20 C.F.R. § 725.503(g) provides: "Each decision and order awarding benefits shall indicate the month from which benefits are payable to the eligible claimant."

[27] The date of the first medical evidence of record indicating total disability does not establish the onset date; rather, such evidence only indicates that the miner became totally disabled at some prior point in time. *Tobrey v. Director, OWCP*, 7 B.L.R. 1-407, 1-409 (1984); *Hall v. Consolidation Coal Co.*, 6 B.L.R. 1-310 (1984). In *Cannelton Industries, Inc. v. Director, OWCP [Frye]*, Case No. 03-1232 (4th Cir. April 5, 2004), the Court affirmed ALJ's use of "0/1" readings between 1986 and 1996 to find opacities present (not CWP) and support an onset date by 1997 when an X-ray produced a category 1 interpretation.

[28] *Dempsey v. Sewell Coal Co. & Director, OWCP*, __ B.L.R. __, BRB Nos. 03-0615 BLA and 03-0615 BLA-A (June 28, 2004). ALJ merely concluded, in general terms, that the evidence did not establish an exact date of onset of total disability. This was error. In determining the onset date, the Administrative Law Judge must consider all relevant evidence of record and assess the credibility of that evidence. *Lykins, supra* at 1-183.

An application by the claimant's attorney for approval of a fee has not been received: therefore no an award of attorney's fees for services is made. Thirty days is hereby allowed to the claimant's counsel for submission of such an application. Counsels' attention is directed to 20 C.F.R. §§ 725.365-725.366. A service sheet showing that service has been made upon all the parties, including the claimant, must accompany the application. Parties have ten days following receipt of any such application within which to file any objections. The Act prohibits charging a fee in the absence of an approved application.

CONCLUSIONS

In conclusion, the claimant has established that a material change in conditions has taken place since the previous denial, because he has established the existence of pneumoconiosis. The miner had pneumoconiosis, as defined by the Act and Regulations. The pneumoconiosis arose out of his coal mine employment. The miner was totally disabled. His total disability was due to pneumoconiosis. He is therefore entitled to benefits.

ORDER[29]

It is ordered that the claim of Thomas Fudala on behalf of Frank Fudala for benefits under the Black Lung Benefits Act is hereby GRANTED.

It is further ordered that the employer, Gateway Coal Company, shall pay[30] to the claimant all benefits to which he is entitled under the Act commencing June 1, 2003.[31]

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RICHARD A. MORGAN
Administrative Law Judge

PAYMENT IN ADDITION TO COMPENSATION: 20 C.F.R. § 725.530(a)(Applicable to claims adjudicated on or after Jan. 20, 2001) provides that "An operator that fails to pay any benefits that are due, with interest, shall be considered in default with respect to those benefits,

[29] Section 725.478 Filing and service of decision and order (Change effective Jan. 19, 2001). Upon receipt of a decision and order by the DCMWC, the decision and order shall be considered to be filed in the office of the district director, and shall become effective on that date.

[30] 20 C.F.R. § 725.502(a)(1)(65 Fed. Reg. 80085, Dec. 20, 2000) provides "Benefits shall be considered due after the issuance of an effective order requiring the payment of benefits by a district director, administrative law judge, Benefits Review Board, or court, notwithstanding the pendency of a motion for reconsideration before an administrative law judge or an appeal to the Board or court, except that benefits shall not be considered due where the payment of such benefits has been stayed by the Benefits Review Board or appropriate court. An effective order shall remain in effect unless it is vacated."

[31] 20 C.F.R. § 725.530 (within 30 days of this order). In any case in which the fund has paid benefits on behalf of an operator or employer, the latter shall simultaneously with the first payment of benefits to the beneficiary, reimburse the fund (with interest) for the full amount of all such payments. 20 C.F.R. § 725.602(a).

If an employer does not pay benefits after the Director's initial determination of eligibility, it may be ordered to pay the beneficiary simple interest on all past due benefits (and attorney's fee) at a rate according to the Internal Revenue Code § 6621. 20 C.F.R. §§ 725.608(a) and 725.608(c).

and the provisions of § 725.605 of this part shall be applicable. In addition, a claimant who does not receive any benefits within **10 days** of the date they become due is entitled to additional compensation equal to **twenty percent** of those benefits (see § 725.607)."

NOTICE OF APPEAL RIGHTS (Effective Jan. 19, 2001): Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board before the decision becomes final, i.e., at the expiration of thirty (30) days after "filing" (or **receipt by**) with the Division of Coal Mine Workers' Compensation, OWCP, ESA, ("DCMWC"), by filing a Notice of Appeal with the **Benefits Review Board, ATTN: Clerk of the Board, P.O. Box 37601, Washington, D.C. 20013-7601.**[32] At the time you file an appeal with the Board, you **must also send a copy** of the appeal letter to **Donald S. Shire, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210**. *See* 20 C.F.R. § 725.481.

Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).

[32] 20 C.F.R. § 725.479 (Change effective Jan. 19, 2001). (d) Regardless of any defect in service, **actual receipt** of the decision is suffice to commence the 30-day period for requesting reconsideration or appealing the decision.